Sound Medical Family Practice

PATIENT INFORMATION

Last Name: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widow Sex: ☐ Male ☐ Female Age: _____ Birth Date: _____

Race: ☐ White / Caucasian ☐ Black ☐ African American ☐ Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ American Indian ☐ Other _____
☐ Decline

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Decline

Phone #1: _____ ☐ Cell ☐ Home Phone #2: _____ ☐ Cell ☐ Home

Preferred Contact Method: ☐ Cell ☐ Home ☐ Other _____

☐ Yes, it is okay to leave a message regarding my health information on voice mail. ☐ No Messages

Social Security # _____ Email Address _____

Employer Name: _____ Phone #: _____ Occupation _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Relationship: _____

Mailing Address: _____ Phone Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone 1: _____ Phone 2: _____

May this emergency contact have access to your medical records? ☐ Yes ☐ No Initial _____

HIPPA ACKNOWLEDGMENTS

Please initial each line:

_____ I hereby acknowledge that I have been provided with a copy of the privacy policy

_____ I elect the following people to have access to my medical records

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Secondary Insurance Company Name: _____

Deemed Consent | Consent for treatment | Release of Medical Information | No Guarantee | Electronic Communications

I hereby authorize medical treatment by any Sound Medical Family Practice Physician, Physician Assistant, and or affiliated medical staff member. I further authorize release of any and all medical and / or billing information as is necessary for reimbursement from any insurance carrier. I accept responsibility for payment of all treatment that the insurance carrier determines does not constitute as covered services. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. I agree that Sound Medical may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit organizations for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and cell phone number, you consent to receive electronic messages by such means. We will not share your information. You may opt out of electronic communication at any time.

Signature of Patient or Responsible Party **X** _____ Date / /

Relationship to Patient: _____